The Roles of Quality, Safety, and Technology as Financial Risks Are Shifted to Hospitals

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The entire American healthcare system and hospital boards in particular are again at a crossroads. Both were irrevocably transformed in 1965 by the introduction of Medicare and the *Darling* legal decision. Medicare began the shift from private to public funding and *Darling* shifted responsibilities for hospitals' quality of care from physicians to "hospital governing boards."[1] Now, 2016 launches a massive expansion of board responsibilities to include taking full financial risks for Medicare's Comprehensive Care for Joint Replacement (CJR) patients. This latest iteration represents a new healthcare financing model that imposes tremendous economic risks on CJR designated hospitals. But, great risks are accompanied by great opportunities for those who are prepared. CMS will reward hospitals and their medical staffs for delivering high-quality, cost-efficient outcomes, the net saving of which can then be legally shared with physicians.

Quality, Costs, and the CJR Episode

Beginning April 1, 2016, over 800 hospital boards in 67 U.S. regions will experience the full weight of their quality and fiduciary responsibilities. This date begins a preparatory year before CMS mandates the transfer of all financial risks to these hospitals for total hips and knees, including all costs incurred during patients' 90-day post-discharge period. Moreover, CJR heightens the focus on two of the most fundamental, inpatient cost components for which boards are also responsible: quality of care and patient safety. The nexus of medical quality and costs are profound. Over time, high quality is invariably cost-efficient in all industries, but especially in healthcare. This is because one complication or safety infraction doubles or triples a patient's hospital costs. Additionally, high-quality, cost-efficient outcomes define value, which fulfills the highest aspirations of both patients and payers.

All hospitals should use this preparatory year in the likely event the CJR bundle will soon be mandated for all U.S. regions. Under these pressures, collaboration between hospital administrators, boards, and physicians will be paramount. Each hospital should objectively and dispassionately assess its current levels of clinical quality and cost efficiencies, then make whatever course corrections are necessary to ensure net savings are generated. Lower extremity, total joint patients are often the hospitals' largest revenue source and for which negative cash flow could result in extreme financial hardships. Fortunately, CJR providers have a year's preparation to achieve these savings. Also, administrations will need to provide an objective means to equitably distribute the net savings among the hospital and physicians to avoid disputes over money. Clinical quality, patient safety, and cost efficiencies are disciplines in which modern information technology plays a critical role as hospital management and clinicians respond to the challenges posed by bundle payments.

Key Board Takeaways

Medicare's CJR will create significant financial risks for hospital boards and administrations in selected regional areas of the U.S. But, these risks can be offset by reimbursement opportunities for those who are prepared. This is due to the fact that CMS will reward hospitals and their medical staffs for delivering high-quality, cost-efficient outcomes, the net saving of which can then be legally shared with physicians. Three objectives the board should have for CJR and future bundles include:

- Provide physicians with clinical data to reliably produce bundled payment net savings.
- Objectively define clinical quality improvements on which to distribute net savings.
- Transparently share net savings among hospital and physicians, based on quality outcomes.

The Board's Three Objectives for CJR and Future Bundles

1. Provide information technologies for physicians to achieve net savings. The first hospital imperative is to ensure clinical and operational net savings are achieved for CJR patients, including inpatient, physician, and readmission costs. Without a positive cash balance there will be no dollars to offset the hospital's financial risks or to share with doctors. Inpatient expenses are usually over 50 percent of total CJR costs, so clinical and operational efficiencies are critical. Physicians admit, discharge, and direct 75 percent to 85 percent of all inpatient costs; therefore, a net savings at the physician level is key to financial success.

The most effective way to achieve a positive cash flow is for hospital information systems to demonstrate each physician's best-documented use of diagnostic and treatment resources (i.e., labs, pharmaceuticals, etc.). When doctors have their individual risk-adjusted, patient-specific data, they are able to collaborate among themselves and with hospital personnel to construct the most efficient two-level order sets for treating future patients. One order set is for less acutely ill patients and the other for severely ill patients within each diagnostic group, such as pneumonia or total hips.

2. Provide objective and transparent means to distribute net savings among the hospital and physicians. Since hospitals are at risk, they will receive any year-end net savings that are created by efficient patient care. Typically physicians believe their ordering patterns are responsible for generating the majority of these savings. In order to ensure the success of bundle payment episodes, doctors must trust the hospital administrators to accurately reward them with their fair share of net savings, based not only on financial, but also on clinical outcomes. This provider collaboration is a key component of the CJR risk-sharing model that incentivizes doctors to exert extra efforts in order to generate savings for the hospital, for themselves, and ultimately for CMS. Interestingly, net savings can be shared during 2016, a year before the start of hospital risk sharing.

3. Furnish oversight for selecting post-acute providers to manage CJR's 90-day, post-discharge phase. Board oversight for the post-acute selection process is important to current CJR designated hospitals and eventually to all hospitals. Deciding on which nursing homes, home health agencies, and physical therapists for contracting is generally not the expertise of hospital personnel. Administrators and

1 Darling v. Charleston Community Memorial Hospital, 211 N.E.2d 253 (1965).

board members need a strategy with possible outside consulting assistance to select and manage the most effective and efficient providers and agencies that can produce savings in the post-discharge phase. Once identified, physicians will be attentive as to which post-acute care providers they choose when discharging their patients, as prudent selections will increase their share of the episode's net savings.

Quality, Safety, Technology, and the Future of Inpatient Care

Physicians and hospitals are voluntarily pursuing risk-bearing, commercial contracts in order to maintain their incomes, but CJR is not voluntary. For the first time in its history, Medicare is mandating that selected hospitals accept inpatient and post-discharge financial risks for total hips and knees, which are usually a large portion of their businesses. Now that CMS has developed CJR as a working model that transfers significant financial risks onto hospitals, most physicians and healthcare executives believe it is going to be extended, first to other hospitals, then to additional patient groups.

Viability under CJR and future bundle payment models requires conservation of hospitals' finite resources. These efficiency efforts create net savings that are achieved primarily at the physician level. Distributing net savings among the hospital and physician participants using an objective, quality-based method will virtually guarantee physician endorsement and the success of any bundle payment model. To accomplish these quality improvements, patient safety, and efficiency goals, hospital administrations and boards must equip doctors with technologies that produce reliable clinical information for individual physicians, including down to individual lab test and X-ray levels. These tools plus inpatient and post-acute provider collaboration will ensure hospitals' ongoing success as they approach this latest crossroads of American healthcare.

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